

APPETITE SUPPRESSANT INFORMED CONSENT

(WEIGHT NO MORE – ROBERT SKVERSKY, M.D., INC. AND ASSOCIATES)

PROCEDURE AND ALTERNATIVES: I authorize Robert Skversky, M.D., and associates to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

I HAVE READ AND UNDERSTAND MY DOCTOR'S STATEMENTS THAT FOLLOW: "Medications, including the appetite suppressants, have labeling worked out between the maker of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter-term studies (up to 12 weeks) using the dosages indicated in the labeling.

As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses. Such usage has not been as systematically studied as that suggested in the labeling as it is possible, as with most other medications, that there could be serious side effects as noted below. As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. You must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help of appetite suppressants."

I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss.

RISKS OF PROPOSED TREATMENT: I understand this authorization is given with the knowledge that the use of appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. These and other risks could, on occasion, be serious or fatal.

RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE: I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly with more overweight.

NO GUARANTEES: I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful. I understand that payment in full for all visits and testing is due at the time of my visits, and by submitting to services and testing, I agree to pay for same in full. Medicare does not, and Blue Cross and other medical insurance may or may not pay for your treatment. You will be given a statement to send in to your insurance carrier for reimbursement upon request, but payment in full for your services is due at the time of your visits. I acknowledge and agree to pay all fees as follows. All fees subject to change without notice.

PATIENT'S CONSENT: I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. You may contact my MD about my progress.

WARNING: IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR BEFORE SIGNING.

PATIENT'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN / ASSOCIATE DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's related questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies, and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants as stated.

PHYSICIAN'S/ASSOCIATE'S SIGNATURE: _____ **DATE:** _____